FOR OHF USE

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0038752

Facility Name: FAIRFAX NURSING HOME

Address: 3601 S. HARLEM AVE (Number) BERWYN (City) 60402 (Zip Code)

County: COOK

Telephone Number: (708) 749-4160 **Fax #** (708) 749-7696

IDPA ID Number: 363874607001

Date of Initial License for Current Owners: 03/31/93

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) See Accountants' Compilation Report Attached (Date)

(Print Name and Title) EDWARD N. SLACK, C.P.A.

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax# (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number FAIRFAX NURSING HOME # 0038752 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	160	Skilled (SNF)	160	58,400	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	160	TOTALS	160	58,400	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	13,755	3,190	4,131	21,076	8
9	SNF/PED					9
10	ICF	15,101	4,178	912	20,191	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,856	7,368	5,043	41,267	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.66%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 4/16/93

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 4/16/93 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 70 and days of care provided 3332

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number FAIRFAX NURSING HOME # 0038752 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	197,455	32,006	12,555	242,016		242,016	(14,727)	227,289			1
2	Food Purchase		162,771		162,771	(24,090)	138,681	11,213	149,894			2
3	Housekeeping	159,717	40,005		199,722		199,722	1,283	201,005			3
4	Laundry	93,595	19,989		113,584		113,584		113,584			4
5	Heat and Other Utilities			112,813	112,813		112,813	1,700	114,513			5
6	Maintenance	70,394		86,550	156,944		156,944	6,764	163,708			6
7	Other (specify):*							1,938	1,938			7
8	**TOTAL General Services**	521,161	254,771	211,918	987,850	(24,090)	963,760	8,172	971,932			8
	B. Health Care and Programs											
9	Medical Director			22,425	22,425		22,425		22,425			9
10	Nursing and Medical Records	2,014,212	61,894	50,494	2,126,600		2,126,600	(1,004)	2,125,596			10
10a	Therapy	82,464	3,074	28,404	113,942		113,942	(7,429)	106,513			10a
11	Activities	112,429	7,798	3,555	123,782		123,782	233	124,015			11
12	Social Services	62,322		2,193	64,515		64,515	1,276	65,791			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*							9,035	9,035			15
16	**TOTAL Health Care and Programs**	2,271,427	72,766	107,071	2,451,264		2,451,264	2,110	2,453,374			16
	C. General Administration											
17	Administrative	51,342		31,476	82,818		82,818	31,205	114,023			17
18	Directors Fees											18
19	Professional Services			227,605	227,605		227,605	(144,450)	83,155			19
20	Dues, Fees, Subscriptions & Promotions			60,030	60,030		60,030	(27,987)	32,043			20
21	Clerical & General Office Expenses	137,228	19,187	115,114	271,529		271,529	17,411	288,940			21
22	Employee Benefits & Payroll Taxes			490,951	490,951	24,090	515,041	(13,856)	501,185			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,327	3,327		3,327	(113)	3,214			24
25	Other Admin. Staff Transportation			2,648	2,648		2,648	(1,660)	988			25
26	Insurance-Prop.Liab.Malpractice			175,416	175,416		175,416	1,220	176,636			26
27	Other (specify):*							17,021	17,021			27
28	**TOTAL General Administration**	188,570	19,187	1,106,567	1,314,324	24,090	1,338,414	(121,209)	1,217,205			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,981,158	346,724	1,425,556	4,753,438		4,753,438	(110,927)	4,642,511			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number FAIRFAX NURSING HOME #0038752 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			73,339	73,339		73,339	231,240	304,579			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			199,534	199,534		199,534	422,962	622,496			32
33	Real Estate Taxes			222,405	222,405		222,405	2,467	224,872			33
34	Rent-Facility & Grounds			754,756	754,756		754,756	(747,818)	6,938			34
35	Rent-Equipment & Vehicles			5,941	5,941		5,941	2,296	8,237			35
36	Other (specify):*							11,125	11,125			36
37	**TOTAL Ownership**			1,255,975	1,255,975		1,255,975	(77,729)	1,178,246			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	195,191	335,876	157,743	688,810		688,810	(49,437)	639,373			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			87,600	87,600		87,600		87,600			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	195,191	335,876	245,343	776,410		776,410	(49,437)	726,973			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,176,349	682,600	2,926,874	6,785,823		6,785,823	(238,092)	6,547,731			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number FAIRFAX NURSING HOME # 0038752 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	78,031	30		9
10	Interest and Other Investment Income	(3,419)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(287)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(54,855)	21		24
25	Fund Raising, Advertising and Promotional	(18,414)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(600)	20		28
29	Other-Attach Schedule	(35,383)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (34,927)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(203,165)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (203,165)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (238,092)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

FAIRFAX NURSING HOME

ID# 0038752

Report Period Beginning: 01/01/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Il LTC Council COPE	$ (2,932)	20	1
2	Jury Duty (Misc Income)	(279)	10	2
3	Wheel Chair Revenue-(Private)	(492)	35	3
4	Prior Period Legal Fees	(603)	19	4
5	Meal Income	(21)	02	5
6	Veterans Expense	(18,003)	10	6
7	Collection Expense	(3,787)	19	7
8	Theft Loss	(1,090)	21	8
9	Bank Charges	(4,734)	21	9
10	Seminar (Unaccounted invoice/non-allowable)	(984)	24	10
11	IL Replacement Tax (Building Co)	(2,223)	21	11
12	Bank Charges (Building Co)	(5)	21	12
13	LLC Fee (Building Co)	(200)	21	13
14	Marketing Seminar	(30)	24	14
15				15
16				16
17				17
18				18
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STATE OF ILLINOIS

Summary A

Facility Name & ID Number FAIRFAX NURSING HOME # 0038752 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary			3,281	(2,920)		(15,088)						(14,727)	1
2	Food Purchase	(308)		(308)			11,830						11,213	2
3	Housekeeping			1,283									1,283	3
4	Laundry													4
5	Heat and Other Utilities			1,700									1,700	5
6	Maintenance			9,419	(2,657)		2						6,764	6
7	Other (specify):*			1,330			608						1,938	7
8	TOTAL General Services	(308)		16,705	(5,577)		(2,648)						8,172	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(18,282)		19,223	(43,133)	39,354	111	(4,231)			5,954		(1,004)	10
10a	Therapy			3,832	(11,261)								(7,429)	10a
11	Activities			1,484	(1,251)								233	11
12	Social Services			1,396	(120)								1,276	12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*			3,298		5,737							9,035	15
16	TOTAL Health Care and Programs	(18,282)		29,233	(55,766)	45,091	111	(4,231)			5,954		2,110	16
	C. General Administration													
17	Administrative			30,916	(28,301)	28,301	289						31,205	17
18	Directors Fees													18
19	Professional Services	(4,390)		4,532	(125,800)		56				(18,848)		(144,450)	19
20	Fees, Subscriptions & Promotions	(21,946)		1,234	(7,300)		25						(27,987)	20
21	Clerical & General Office Expenses	(63,107)	2,428	88,666	(13,097)		508				2,013		17,411	21
22	Employee Benefits & Payroll Taxes				(14,973)						1,117		(13,856)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(1,014)		898			3						(113)	24
25	Other Admin. Staff Transportation			48	(2,292)		584						(1,660)	25
26	Insurance-Prop.Liab.Malpractice			871							349		1,220	26
27	Other (specify):*			13,440		3,581							17,021	27
28	TOTAL General Administration	(90,457)	2,428	140,605	(191,763)	31,882	1,465				(15,369)		(121,209)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(109,047)	2,428	186,543	(253,105)	76,973	(1,072)	(4,231)			(9,415)		(110,927)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number FAIRFAX NURSING HOME # 0038752 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	78,031	108,958	6,657					37,594				231,240	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(3,419)	409,650	6,967			9		9,204		551		422,962	32
33	Real Estate Taxes			2,467									2,467	33
34	Rent-Facility & Grounds		(753,360)	3,386							2,156		(747,818)	34
35	Rent-Equipment & Vehicles	(492)		2,550			30				208		2,296	35
36	Other (specify):*		11,125										11,125	36
37	TOTAL Ownership	74,120	(223,627)	22,027			39		46,797		2,915		(77,729)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(2,226)	(411)	(46,800)				(49,437)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers						(2,226)	(411)	(46,800)				(49,437)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(34,927)	(221,199)	208,570	(253,105)	76,973	(3,259)	(4,642)	(3)		(6,500)		(238,092)	45

Facility Name & ID Number FAIRFAX NURSING HOME # 0038752 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Fairfax Health Care Properties		Building company

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 753,360	Fairfax Health Care Properties	100.00%	$	$ (753,360)	1
2	V	32	Interest Income		Fairfax Health Care Properties	100.00%	(194,442)	(194,442)	2
3	V	32	Interest Expense		Fairfax Health Care Properties	100.00%	604,092	604,092	3
4	V	21	Bank Charges		Fairfax Health Care Properties	100.00%	5	5	4
5	V	36	Amortization		Fairfax Health Care Properties	100.00%	11,125	11,125	5
6	V	30	Depreciation		Fairfax Health Care Properties	100.00%	108,958	108,958	6
7	V	21	Illinois Replacement Tax		Fairfax Health Care Properties	100.00%	2,223	2,223	7
8	V	21	LLC Fee		Fairfax Health Care Properties	100.00%	200	200	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 753,360			$ 532,161	$ * (221,199)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FAIRFAX NURSING HOME # 0038752 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	$	CARE CENTERS, INC.	100.00%	$ 3,281	$ 3,281	15
16	V	2	FOOD		CARE CENTERS, INC.	100.00%	(308)	(308)	16
17	V	3	HOUSEKEEPING		CARE CENTERS, INC.	100.00%	1,283	1,283	17
18	V	5	UTILITIES		CARE CENTERS, INC.	100.00%	1,700	1,700	18
19	V	6	REPAIRS AND MAINT.		CARE CENTERS, INC.	100.00%	9,419	9,419	19
20	V	7	EMP. BEN. - GEN. SERV.		CARE CENTERS, INC.	100.00%	1,330	1,330	20
21	V	10	NURSING		CARE CENTERS, INC.	100.00%	19,223	19,223	21
22	V	10A	THERAPY		CARE CENTERS, INC.	100.00%	3,832	3,832	22
23	V	11	ACTIVITIES		CARE CENTERS, INC.	100.00%	1,484	1,484	23
24	V	12	SOCIAL SERVICES		CARE CENTERS, INC.	100.00%	1,396	1,396	24
25	V	15	EMP. BEN. - HEALTHCARE		CARE CENTERS, INC.	100.00%	3,298	3,298	25
26	V	17	ADMINISTRATIVE		CARE CENTERS, INC.	100.00%	30,916	30,916	26
27	V	19	PROFESSIONAL FEES		CARE CENTERS, INC.	100.00%	4,532	4,532	27
28	V	20	DUES, SUBSCRIPTIONS		CARE CENTERS, INC.	100.00%	1,234	1,234	28
29	V	21	CLERICAL AND GENERAL		CARE CENTERS, INC.	100.00%	88,666	88,666	29
30	V	24	SEMINARS		CARE CENTERS, INC.	100.00%	898	898	30
31	V	25	AUTO EXPENSE		CARE CENTERS, INC.	100.00%	48	48	31
32	V	26	INSURANCE		CARE CENTERS, INC.	100.00%	871	871	32
33	V	27	EMP. BEN. - GEN. ADMIN.		CARE CENTERS, INC.	100.00%	13,440	13,440	33
34	V	30	DEPRECIATION		CARE CENTERS, INC.	100.00%	6,657	6,657	34
35	V	32	INTEREST		CARE CENTERS, INC.	100.00%	6,967	6,967	35
36	V	33	REAL ESTATE TAXES		CARE CENTERS, INC.	100.00%	2,467	2,467	36
37	V	34	BUILDING RENT - UNRELATED		CARE CENTERS, INC.	100.00%	3,386	3,386	37
38	V	35	EQUIPMENT RENTAL		CARE CENTERS, INC.	100.00%	2,550	2,550	38
39	Total			$			$ 208,570	$ * 208,570	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FAIRFAX NURSING HOME # 0038752 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY CONS	$ 2,920	CARE CENTERS, INC.	100.00%	$	$ (2,920)	15
16	V	19	ACCOUNTING	16,500	CARE CENTERS, INC.	100.00%		(16,500)	16
17	V	19	ANCIL ADMIN FEE	9,600	CARE CENTERS, INC.	100.00%		(9,600)	17
18	V	19	BOOKEEPING	16,320	CARE CENTERS, INC.	100.00%		(16,320)	18
19	V	19	DATA PROCESSING	2,880	CARE CENTERS, INC.	100.00%		(2,880)	19
20	V	19	LEGAL	7,300	CARE CENTERS, INC.	100.00%		(7,300)	20
21	V	19	MANAGEMENT FEE	67,200	CARE CENTERS, INC.	100.00%		(67,200)	21
22	V	19	PROFESSIONAL FEES	6,000	CARE CENTERS, INC.	100.00%		(6,000)	22
23	V	20	ADVERTISING	7,300	CARE CENTERS, INC.	100.00%		(7,300)	23
24	V	25	REBILL BUS	2,292	CARE CENTERS, INC.	100.00%		(2,292)	24
25	V				CARE CENTERS, INC.	100.00%			25
26	V	22	HOME OFFICE PAYROLL TAX	14,973	CARE CENTERS, INC.	100.00%		(14,973)	26
27	V	1	REBILL. PAYROLL DIETARY		CARE CENTERS, INC.	100.00%			27
28	V	3	REBILL. PAYROLL HSKPNG		CARE CENTERS, INC.	100.00%			28
29	V	6	REBILL. PAYROLL MAINT.	2,657	CARE CENTERS, INC.	100.00%		(2,657)	29
30	V	10	REBILL. PAYROLL NURSING	43,133	CARE CENTERS, INC.	100.00%		(43,133)	30
31	V	10A	REBILL. PAYROLL THPY CONS.	11,261	CARE CENTERS, INC.	100.00%		(11,261)	31
32	V	11	REBILL. PAYROLL ACTIVITIES	1,251	CARE CENTERS, INC.	100.00%		(1,251)	32
33	V	12	REBILL. PAYROLL SOC. SERV.	120	CARE CENTERS, INC.	100.00%		(120)	33
34	V	17	REBILL. PAYROLL ADMIN.	28,301	CARE CENTERS, INC.	100.00%		(28,301)	34
35	V	21	REBILL. PAYROLL CLERICAL	13,097	CARE CENTERS, INC.	100.00%		(13,097)	35
36	V								36
37	V								37
38	V								38
39	Total			$ 253,105			$	$ * (253,105)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FAIRFAX NURSING HOME # 0038752 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	NURSING	$	CARE CENTERS, INC.	100.00%	$ 39,354	$ 39,354	15
16	V	15	EMP. BEN HEALTHCARE		CARE CENTERS, INC.	100.00%	5,737	5,737	16
17	V	17	ADMINISTRATIVE		CARE CENTERS, INC.	100.00%	28,301	28,301	17
18	V	27	EMP. BEN GEN. ADMIN.		CARE CENTERS, INC.	100.00%	3,581	3,581	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 76,973	$ * 76,973	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FAIRFAX NURSING HOME # 0038752 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	$	CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%	$ 6,684	$ 6,684	15
16	V	2	FOOD		CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%	11,830	11,830	16
17	V	6	MAINTENANCE		CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%	2	2	17
18	V	7	EMP. BEN. - GEN. SERV.		CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%	608	608	18
19	V	10	NURSING		CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%	111	111	19
20	V	17	ADMINISTRATIVE		CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%	289	289	20
21	V	19	PROFESSIONAL FEES		CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%	56	56	21
22	V	20	DUES, FEES, SUB.		CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%	25	25	22
23	V	21	CLERICAL & GENERAL		CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%	508	508	23
24	V	24	SEMINARS		CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%	3	3	24
25	V	25	TRAVEL		CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%	584	584	25
26	V	32	INTEREST		CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%	9	9	26
27	V	35	RENT - EQUIPMENT & VEHICLES		CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%	30	30	27
28	V	39	ANCILLARY ENTERAL SUPPLIES		CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%	386	386	28
29	V	1	DIETARY SUPP	21,772	CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%		(21,772)	29
30	V	39	ANCILLARY SUPP	2,612	CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%		(2,612)	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 24,384			$ 21,125	$ * (3,259)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FAIRFAX NURSING HOME # 0038752 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	MEDICAL SUPPLIES	$	XCEL MEDICAL SUPPLLY LLC	100.00%	$ 34,837	$ 34,837	15
16	V	39	MEDICAL SUPPLIES		XCEL MEDICAL SUPPLLY LLC	100.00%	3,387	3,387	16
17	V								17
18	V								18
19	V	10	MEDICAL SUPPLIES	39,068	XCEL MEDICAL SUPPLLY LLC	100.00%		(39,068)	19
20	V	39	MEDICAL SUPPLIES	3,798	XCEL MEDICAL SUPPLLY LLC	100.00%		(3,798)	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 42,866			$ 38,224	$ * (4,642)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FAIRFAX NURSING HOME # 0038752 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	DEPRECIATION	$	VENTLEASE LLC	100.00%	$ 37,594	$ 37,594	15
16	V	32	INTEREST				9,204	9,204	16
17	V								17
18	V								18
19	V	39	ANCILLARY EQUIP RENT	46,800	VENTLEASE LLC	100.00%		(46,800)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 46,800			$ 46,797	$ * (3)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FAIRFAX NURSING HOME # 0038752 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INS.	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 74,506	$ 74,506	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INS.	74,506	CCS EMPLOYEE BENEFIT GROUP	100.00%		(74,506)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 74,506			$ 74,506	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FAIRFAX NURSING HOME # 0038752 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Nurse Consultant	$	Pinnacle Care Health Services LLC		$ 5,954	$ 5,954	15
16	V	21	Office Expenses		Pinnacle Care Health Services LLC		2,013	2,013	16
17	V	22	Employee Benefits		Pinnacle Care Health Services LLC		1,117	1,117	17
18	V	26	Insurance		Pinnacle Care Health Services LLC		349	349	18
19	V	32	Interest		Pinnacle Care Health Services LLC		551	551	19
20	V	34	Building Rent		Pinnacle Care Health Services LLC		2,156	2,156	20
21	V	35	Equipment Rent		Pinnacle Care Health Services LLC		208	208	21
22	V	19	Home Office Expense	18,848	Pinnacle Care Health Services LLC			(18,848)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 18,848			$ 12,348	$ * (6,500)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FAIRFAX NURSING HOME # 0038752 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FAIRFAX NURSING HOME # 0038752 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Eric Rothner	Owner	Administrative	26.81%	See Attached	1.33	1.85%		$		1
2	Norm Goldberg	Owner	Administrative	0.34%	See Attached	1.36	2.72%	Salary Alloc	2,736	17-7	2
3	Ariel Goldberg	Relative	Clerical		See Attached	.12	2.75%	Salary Alloc	68	21-7	3
4	Zev Goldberg	Relative	Clerical		See Attached	.70	2.72%	Salary Alloc	453	21-7	4
5	Ron Abrams	Owner	Administrative	3.43%	See Attached	.25	0.71%				5
6	Alan Abrams	Owner	Administrative	3.43%	See Attached	.25	0.71%				6
7	Nathan Langsner	Owner	Administrative	1.03%	See Attached	1.08	2.70%	Salary Alloc	1,998	17-7	7
8	Mark Steinberg	Relative	Administrative		See Attached	1.36	2.72%	Salary Alloc	1,204	17-7	8
9											9
10											10
11											11
12											12
13								TOTAL	$ 6,459		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number FAIRFAX NURSING HOME # 0038752 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number FAIRFAX NURSING HOME # 0038752 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	PATIENT DAYS	1,522,375	33	$ 121,047	$ 120,871	41,268	$ 3,281	1
2	2	FOOD	PATIENT DAYS	1,522,375	33	(11,374)		41,268	(308)	2
3	3	HOUSEKEEPING	PATIENT DAYS	1,522,375	33	47,342	43,569	41,268	1,283	3
4	5	UTILITIES	PATIENT DAYS	1,522,375	33	62,714		41,268	1,700	4
5	6	REPAIRS AND MAINT.	PATIENT DAYS	1,522,375	33	347,481	212,397	41,268	9,419	5
6	7	EMP. BEN. - GEN. SERV.	PATIENT DAYS	1,522,375	33	49,052		41,268	1,330	6
7	10	NURSING	PATIENT DAYS	1,522,375	33	709,129	712,466	41,268	19,223	7
8	10A	THERAPY	PATIENT DAYS	1,522,375	33	141,364	140,790	41,268	3,832	8
9	11	ACTIVITIES	PATIENT DAYS	1,522,375	33	54,745	53,877	41,268	1,484	9
10	12	SOCIAL SERVICES	PATIENT DAYS	1,522,375	33	51,491	51,491	41,268	1,396	10
11	15	EMP. BEN. - HEALTHCARE	PATIENT DAYS	1,522,375	33	121,645		41,268	3,298	11
12	17	ADMINISTRATIVE	PATIENT DAYS	1,522,375	33	1,140,506	1,135,183	41,268	30,916	12
13	19	PROFESSIONAL FEES	PATIENT DAYS	1,522,375	33	167,175		41,268	4,532	13
14	20	DUES, SUBSCRIPTIONS	PATIENT DAYS	1,522,375	33	45,541		41,268	1,234	14
15	21	CLERICAL AND GENERAL	PATIENT DAYS	1,522,375	33	3,270,885	2,869,864	41,268	88,666	15
16	24	SEMINARS	PATIENT DAYS	1,522,375	33	33,128		41,268	898	16
17	25	AUTO EXPENSE	PATIENT DAYS	1,522,375	33	1,780		41,268	48	17
18	26	INSURANCE	PATIENT DAYS	1,522,375	33	32,120		41,268	871	18
19	27	EMP. BEN. - GEN. ADMIN.	PATIENT DAYS	1,522,375	33	495,816		41,268	13,440	19
20	30	DEPRECIATION	PATIENT DAYS	1,522,375	33	245,564		41,268	6,657	20
21	32	INTEREST	PATIENT DAYS	1,522,375	33	257,009		41,268	6,967	21
22	33	REAL ESTATE TAXES	PATIENT DAYS	1,522,375	33	91,002		41,268	2,467	22
23	34	BUILDING RENT - UNRELATE	PATIENT DAYS	1,522,375	33	124,898		41,268	3,386	23
24	35	EQUIPMENT RENTAL	PATIENT DAYS	1,522,375	33	94,062		41,268	2,550	24
25	TOTALS					$ 7,694,122	$ 5,340,509		$ 208,570	25

Facility Name & ID Number FAIRFAX NURSING HOME # 0038752 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number FAIRFAX NURSING HOME # 0038752 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	DIRECT ALLOCATION		7	384,296	384,296		39,354	1
2	15	EMP. BEN HEALTHCARE	DIRECT ALLOCATION		7	49,011			5,737	2
3	17	ADMINISTRATIVE	DIRECT ALLOCATION		27	1,367,742	1,367,742		28,301	3
4	27	EMP. BEN GEN. ADMIN.	DIRECT ALLOCATION		27	180,242			3,581	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,981,291	$ 1,752,038		$ 76,973	25

Facility Name & ID Number FAIRFAX NURSING HOME # 0038752 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	HEALTH SYSTEMS INC.	2,322,899	28	578,157	413,013	26,854	6,684	1
2	2	FOOD	HEALTH SYSTEMS INC.	2,322,899	28	1,023,347		26,854	11,830	2
3	6	MAINTENANCE	HEALTH SYSTEMS INC.	2,322,899	28	185		26,854	2	3
4	7	EMP. BEN. - GEN. SERV.	HEALTH SYSTEMS INC.	2,322,899	28	52,590		26,854	608	4
5	10	NURSING	HEALTH SYSTEMS INC.	2,322,899	28	9,570		26,854	111	5
6	17	ADMINISTRATIVE	HEALTH SYSTEMS INC.	2,322,899	28	25,000		26,854	289	6
7	19	PROFESSIONAL FEES	HEALTH SYSTEMS INC.	2,322,899	28	4,819		26,854	56	7
8	20	DUES, FEES, SUB.	HEALTH SYSTEMS INC.	2,322,899	28	2,196		26,854	25	8
9	21	CLERICAL & GENERAL	HEALTH SYSTEMS INC.	2,322,899	28	43,980		26,854	508	9
10	24	SEMINARS	HEALTH SYSTEMS INC.	2,322,899	28	257		26,854	3	10
11	25	TRAVEL	HEALTH SYSTEMS INC.	2,322,899	28	50,512		26,854	584	11
12	32	INTEREST	HEALTH SYSTEMS INC.	2,322,899	28	801		26,854	9	12
13	35	RENT - EQUIPMENT & VEHICI	HEALTH SYSTEMS INC.	2,322,899	28	2,624		26,854	30	13
14	39	ANCILLARY ENTERAL SUPPL	HEALTH SYSTEMS INC.	2,322,899	28	33,430		26,854	386	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,827,468	$ 413,013		$ 21,125	25

Facility Name & ID Number FAIRFAX NURSING HOME # 0038752 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: XCEL MEDICAL SUPPLY LLC
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-2330
Fax Number: (708)449-3236

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	MEDICAL SUPPLIES	DIRECT ALLOCATION			$	$		$ 34,837	1
2	39	MEDICAL SUPPLIES	DIRECT ALLOCATION						3,387	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 38,224	25

Facility Name & ID Number FAIRFAX NURSING HOME # 0038752 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: VENTLEASE LLC
Street Address: 4101 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	DEPRECIATION	DIRECT ALLOCATION			$	$		$ 37,594	1
2	32	INTEREST	DIRECT ALLOCATION						9,204	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 46,797	25

Facility Name & ID Number FAIRFAX NURSING HOME # 0038752 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS EMPLYEE BENEFITS GROUP, INC.
Street Address: 4101 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INS.	DIRECT ALLOCATION			$	$		$ 74,506	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 74,506	25

Facility Name & ID Number FAIRFAX NURSING HOME # 0038752 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Pinnacle Care Health Services LLC
Street Address: 1010 Milwaukee Ave
City / State / Zip Code: Deerfield, IL 60015
Phone Number: ((847) 541-9100
Fax Number: ((847) 541-9015

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Nurse Consultant	Patient Days	158,482	3	$ 22,864	$	41,268	$ 5,954	1
2	21	Office Expenses	Patient Days	158,482	3	7,729		41,268	2,013	2
3	22	Employee Benefits	Patient Days	158,482	3	4,287		41,268	1,117	3
4	26	Insurance	Patient Days	158,482	3	1,340		41,268	349	4
5	32	Interest	Patient Days	158,482	3	2,115		41,268	551	5
6	34	Building Rent	Patient Days	158,482	3	8,280		41,268	2,156	6
7	35	Equipment Rent	Patient Days	158,482	3	800		41,268	208	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 47,415	$		$ 12,348	25

Facility Name & ID Number FAIRFAX NURSING HOME # 0038752 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number FAIRFAX NURSING HOME # 0038752 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Nomura		X	Mortgage			$	$ 6,653,974			$ 604,092	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Shareholder Loans	X		Working Capital				325,000			13,221	6
7	Mempco		X	Insurance Financing							6,996	7
8	Diawa		X	Line of Credit				501,940			41,124	8
9	TOTAL Facility Related						$	$ 7,480,914			$ 665,433	9
	B. Non-Facility Related*											
10	See Supplemental Schedule										(43,487)	10
11	Pinnacle Care allocation										551	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (42,936)	14
15	TOTALS (line 9+line14)						$	$ 7,480,914			$ 622,497	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number FAIRFAX NURSING HOME # 0038752 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	Hunter Management	X					$	$			$ 6,688	1
2	Care Center Allocation										6,976	2
3	Ventlease Allocation										9,204	3
4	Interest Income-(Escrow Acct)										(1,545)	4
5	Interest Income (Bldg Co.)										(64,810)	5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ (43,487)	21

Facility Name & ID Number FAIRFAX NURSING HOME # 0038752 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.		$ 224,464	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 223,316	2
3. Under or (over) accrual (line 2 minus line 1).		$ (1,148)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 226,020	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 224,872	7

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	178,206	8
	1997	184,115	9
	1998	206,946	10
	1999	222,056	11
	2000	220,849	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

2001 Accrual-$220,849x102.34%=226,016.87

CCI Real Estate Allocation-$2,467

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME FAIRFAX NURSING HOME COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0038752

CONTACT PERSON REGARDING THIS REPORT STEVE LAVENDA

TELEPHONE 847-236-1111 FAX #: 847-236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	16-31-308-001-0000	Long Term Care Facility Property	$ 53,134.45	$ 53,134.45
2.	16-31-308-002-0000	Long Term Care Facility Property	$ 50,224.46	$ 50,224.46
3.	16-31-308-003-0000	Long Term Care Facility Property	$ 14,966.90	$ 14,966.90
4.	16-31-308-004-0000	Long Term Care Facility Property	$ 52,298.54	$ 52,298.54
5.	16-31-308-005-0000	Long Term Care Facility Property	$ 50,224.46	$ 50,224.46
6.			$	$
7.	Care Center Inc.	Facility Allocation	$ 66,986.83	$ 1,815.86
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 287,835.64	$ 222,664.67

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number FAIRFAX NURSING HOME # 0038752 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 44,431 B. General Construction Type: Exterior Brick Frame Concrete Steel Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1994	$ 50,387	1
2	Alloc from Care Center		1998	1,735	2
3	TOTALS			$ 52,122	3

Facility Name & ID Number FAIRFAX NURSING HOME # 0038752 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1993	21,055			1,053	1,053	8,933	9
10	Various			1994	115,390			5,770	5,770	42,514	10
11	Various			1995	20,692			1,033	1,033	6,551	11
12	Various			1996	183,389			9,170	(9,170)	45,628	12
13	Various			1997	65,643			3,285	3,285	14,671	13
14								-		-	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number FAIRFAX NURSING HOME # 0038752 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		2,945,272	75,551		146,628	71,077	975,257	68
69	Financial Statement Depreciation			22,676			(22,676)		69
70	TOTAL (lines 4 thru 69)		$ 3,351,441	$ 98,227		$ 166,939	$ 50,372	$ 1,093,554	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRFAX NURSING HOME # 0038752 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,351,441	$ 98,227		$ 166,939	$ 68,712	$ 1,093,554	1
2	PLUMBING RENOV	1998	15,425			771	771	3,084	2
3	HVAC RENOV	1998	1,157			58	58	232	3
4	ROOFING	1998	850			43	43	168	4
5	CENTRAL STATION	1998	85,555			4,278	4,278	16,756	5
6	ELECTRICAL	1998	2,024			101	101	387	6
7	PLUMBING	1998	1,991			100	100	383	7
8	CENTRAL SYSTEM	1998	8,374			419	419	1,606	8
9	ELECTRICA	1998	851			43	43	158	9
10	WINDOWS	1998	1,312			66	66	237	10
11	DOOR	1998	762			38	38	136	11
12	HVAC RENOV	1998	5,266			263	263	942	12
13	ELECTRICAL	1998	1,483			74	74	265	13
14	WALLPAPER	1998	6,319			316	316	1,185	14
15	SHOWER RENOV	1998	9,739			487	487	1,826	15
16	CUBICLE CURTAINS	1998	2,525			126	126	473	16
17	CRASH RAILS	1998	13,553			678	678	2,486	17
18	CUBICLE CURTAINS	1998	4,250			213	213	781	18
19	HVAC RENOV	1998	7,886			394	394	1,412	19
20	FLOOR	1998	4,773			239	239	856	20
21	WALLPAPER REMOVAL	1998	950			48	48	156	21
22	TUCKPOINTING	1998	850			43	43	140	22
23	PLASTER	1998	1,000			50	50	163	23
24	COUNTER TOPS	1998	1,950			98	98	319	24
25	HVAC RENOV	1998	3,393			170	170	553	25
26	COUNTER TOPS	1998	2,575			129	129	409	26
27	HVAC RENOV	1998	1,447			72	72	228	27
28	ELECTRICAL RENOV	1998	521			26	26	82	28
29	CLEAN SUMP PUMP	1998	525			26	26	91	29
30	ROOF REPAIR	1998	4,300			215	215	753	30
31	DRYWALL	1998	2,500			125	125	438	31
32	AVIARY	1998	11,968			598	598	2,043	32
33	PAINTING	1998	575			29	29	99	33
34	TOTAL (lines 1 thru 33)		$ 3,558,090	$ 98,227		$ 177,275	$ 79,048	$ 1,132,401	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRFAX NURSING HOME # 0038752 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,558,090	$ 98,227		$ 177,275	$ 79,048	$ 1,132,401	1
2	NEON'S	1998	1,580			79	79	270	2
3	HVAC RENOV	1998	660			33	33	113	3
4	LOUVERS	1998	1,794			90	90	300	4
5	PLUMBING RENOV	1998	604			30	30	100	5
6	SECURITY SYSTEM	1998	1,250			63	63	252	6
7	NOMAI PATIO LIGHTS	1998	805			40	40	160	7
8	GENERATOR RENOVATION	1998	658			33	33	113	8
9	COOLER RENOVATION	1998	1,646			82	82	280	9
10	NURSE CALL SYSTEM	1998	3,960			198	198	726	10
11	TILE-3RD FLOOR	1999	2,650			133	133	399	11
12	TILE-3RD FLOOR	1999	625			31	31	93	12
13	PLUMBING	1999	8,644			432	432	1,296	13
14	PLUMBING	1999	1,133			57	57	171	14
15	PLUMBING	1999	1,197			60	60	180	15
16	HVAC REPAIR	1999	630			32	32	96	16
17	GENERATOR REPAIR	1999	503			25	25	75	17
18	GENERATOR REPAIR	1999	627			31	31	93	18
19	RENOVATION-9 ROOMS	1999	5,100			255	255	744	19
20	PAINT	1999	1,277			64	64	187	20
21	TILES	1999	8,000			400	400	1,167	21
22	TILES	1999	3,522			176	176	513	22
23	HOT WATER TANK REP	1999	2,300			115	115	345	23
24	HVAC REPAIR	1999	571			29	29	85	24
25	DOORS	1999	1,092			55	55	151	25
26	WALLPAPER	1999	535			27	27	74	26
27	PLUMBING REP	1999	7,484			374	374	1,029	27
28	PAINTING-2ND FLOOR	1999	1,650			83	83	235	28
29	DOORS	1999	13,074			654	654	1,853	29
30	VINYL TILES	1999	516			26	26	74	30
31	VERTICAL BLINDS	1999	589			29	29	82	31
32	PLUMBING-KITCHEN	1999	3,030			152	152	431	32
33	REMODELING-9 PT ROOM	1999	17,533			877	877	2,485	33
34	TOTAL (lines 1 thru 33)		$ 3,653,329	$ 98,227		$ 182,040	$ 83,813	$ 1,146,573	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRFAX NURSING HOME # 0038752 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,653,329	$ 98,227		$ 182,040	$ 83,813	$ 1,146,573	1
2	TILES-KITCHEN	1999	9,004			450	450	1,275	2
3	ELECTRICAL REPAIR	1999	3,310			166	166	470	3
4	PLUMBING - 2ND FLOOR	1999	657			33	33	94	4
5	FIXTURES	1999	2,014			101	101	286	5
6	ELECTRICAL WIRING	1999	795			40	40	113	6
7	NEW TILES-SHOWER	1999	611			31	31	85	7
8	METAL DOOR	1999	618			31	31	78	8
9	FIRE SYSTEM REPAIR	1999	1,520			76	76	184	9
10	AC REPAIR	1999	574			29	29	70	10
11	ELEVATOR REPAIR	1999	938			47	47	114	11
12	PLUMBING REPAIR	1999	2,173			109	109	263	12
13	PLUMBING WORK	1999	1,225			61	61	142	13
14	PAINTING	1999	1,800			90	90	210	14
15	UCT INSTALLATION	1999	245			12	12	27	15
16	DOORS	1999	4,328			216	216	486	16
17	GENERATOR RENOV	1999	1,163			58	58	155	17
18	A/C REPAIR	2000	509			25	25	50	18
19	PLUMBING REPAIR	2000	1,469			73	73	146	19
20	PLUMBING REPAIR	2000	643			32	32	64	20
21	PLUMBING REPAIR	2000	301			15	15	30	21
22	BOILER REPAIR	2000	758			38	38	73	22
23	PLUMBING REPAIR	2000	1,791			90	90	173	23
24	PLUMBING REPAIR	2000	828			41	41	79	24
25	DECORATING	2000	1,900			95	95	174	25
26	PLUMBING RENOVATION	2000	671			34	34	62	26
27	FIRE SYSTEM UPGRADE	2000	685			34	34	62	27
28	DECORATING	2000	1,850			93	93	171	28
29	VINYL TILE	2000	7,150			358	358	627	29
30	PLUMBING RENOVATION	2000	832			42	42	74	30
31	FLOOR	2000	830			42	42	70	31
32	PLUMBING	2000	3,218			161	161	268	32
33	WIRING	2000	1,050			53	53	88	33
34	TOTAL (lines 1 thru 33)		$ 3,708,789	$ 98,227		$ 184,816	$ 86,589	$ 1,152,836	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRFAX NURSING HOME # 0038752 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 3,708,789	$ 98,227		$ 184,816	$ 86,589	$ 1,152,836	1
2	WIRING	2000	1,735			87	87	145	2
3	WIRING	2000	550			28	28	44	3
4	WIRING	2000	140			7	7	11	4
5	TILING	2000	4,190			210	210	315	5
6	ELECTRICAL REPAIR	2000	8,012			801	801	1,202	6
7	WIRING-LOBBY CEILING	2000	2,073			104	104	156	7
8	SHIPPING CHARGES VCT	2000	431			22	22	31	8
9	DUCKWORK	2000	565			28	28	40	9
10	HEAT DETECTOR REPAIR	2000	824			41	41	58	10
11	MIRRORS	2000	4,506			225	225	319	11
12	DRAPES	2000	1,946			97	97	137	12
13	WIRING	2000	610			31	31	44	13
14	TUCKPOINTING	2000	350			18	18	26	14
15	SLOPE TOP FIN TUBE	2000	5,228			261	261	326	15
16	INSTALLATION OF DRAP	2000	857			43	43	54	16
17	WIRING IN KITCHEN	2000	610			31	31	39	17
18	DOOR SYSTEMS	2000	1,424			71	71	89	18
19	PAINTING HAZARD ROOM	2000	1,850			93	93	124	19
20	PLUMBING REPAIR 2&3	2000	1,500			75	75	100	20
21	BOILER #2 REPAIR	2000	1,038			52	52	69	21
22	BOILER #3 REPAIR	2000	870			44	44	59	22
23	SHOWER ROOM FIN TUBE	2000	1,330			67	67	89	23
24	PLUMBING REPAIR	2000	1,231			62	62	83	24
25	PUMP MOTOR	2000	1,040			52	52	56	25
26	PUMP MOTOR	2000	533			27	27	29	26
27	SEWER REPAIR	2000	744			37	37	40	27
28	SEWER REPAIR	2000	3,504			175	175	190	28
29	PLUMBING REPAIR	2000	624			31	31	34	29
30	FIRE ALARM REPAIR	2000	1,143			57	57	62	30
31	DOOR KNOBS	2000	781			39	39	78	31
32	TELEPHONE SYSTEM	2000	1,247			62	62	114	32
33	DOOR EXIT DEVICE	2000	869			43	43	75	33
34	TOTAL (lines 1 thru 33)		$ 3,761,144	$ 98,227		$ 187,837	$ 89,610	$ 1,157,074	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRFAX NURSING HOME # 0038752 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 3,761,144	$ 98,227		$ 187,837	$ 89,610	$ 1,157,074	1
2	CHAIRRAILS	2000	1,430			72	72	126	2
3	PLUMBING	2000	1,194			60	60	95	3
4	CHAIRRAIL	2000	889			44	44	70	4
5	COUNTERTOP	2000	4,357			218	218	273	5
6	PHONES	2000	804			40	40	47	6
7	PHONE SYSTEM REPAIR	2000	383			19	19	22	7
8	ELEVATOR REPAIR	2001	588			29	29	29	8
9	ELEVATOR REPAIR	2001	607			30	30	30	9
10	PAINT	2001	664			33	33	33	10
11	VERTICAL BLINDS	2001	1,203			60	60	60	11
12	PLUMBING REPAIR	2001	3,715			171	171	171	12
13	PLUMBING REPAIR	2001	1,294			54	54	54	13
14	A/C REPAIR	2001	1,406			58	58	58	14
15	GENERATOR REPAIR	2001	735			31	31	31	15
16	SERVICE CALL-PLMB RP	2001	1,671			56	56	56	16
17	ROOF UPGRADE	2001	1,600			33	33	33	17
18	TILES	2001	2,396			30	30	30	18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,786,080	$ 98,227		$ 188,875	$ 90,648	$ 1,158,292	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRFAX NURSING HOME # 0038752 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 3,786,080	$ 98,227		$ 188,875	$ 90,648	$ 1,158,292	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,786,080	$ 98,227		$ 188,875	$ 90,648	$ 1,158,292	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRFAX NURSING HOME # 0038752 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 3,786,080	$ 98,227		$ 188,875	$ 90,648	$ 1,158,292	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,786,080	$ 98,227		$ 188,875	$ 90,648	$ 1,158,292	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRFAX NURSING HOME # 0038752 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 3,786,080	$ 98,227		$ 188,875	$ 90,648	$ 1,158,292	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,786,080	$ 98,227		$ 188,875	$ 90,648	$ 1,158,292	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRFAX NURSING HOME # 0038752 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1996		$ 30,703	$ 787	35	$ 877	$ 90	$ 4,459	4
5			1993		2,906,534	74,527	20	145,327	70,800	968,847	5
6											6
7											7
8											8
	Improvement Type**										
9											9
10	Allocation from Care Centers, Inc.			2001	87	11	20	2	(9)	2	10
11	Allocation from Care Centers, Inc.			2000	37	1	20	2	1	3	11
12	Allocation from Care Centers, Inc.			1999	550	14	20	28	(14)	80	12
13	Allocation from Care Centers, Inc.			1998	227	6	20	11	5	42	13
14	Allocation from Care Centers, Inc.			1997	3,220	57	20	178	121	1,038	14
15	Allocation from Care Centers, Inc.			1996	3,540	47	20	187	140	733	15
16	Allocation from Care Centers, Inc.			1994	-	11	20	-	(11)	-	16
17	Allocation from Care Centers, Inc.			1993	-	3	20	-	(3)	-	17
18	Allocation from Care Centers, Inc.			1995	374	87	20	16	(71)	53	18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number FAIRFAX NURSING HOME # 0038752 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
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58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,945,272	$ 75,551		$ 146,628	$ 71,049	$ 975,257	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRFAX NURSING HOME # 0038752 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,116,623	$ 125,786	$ 111,764	$ (14,022)		$ 665,277	71
72	Current Year Purchases	26,245	264	1,665	1,401		1,665	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,142,868	$ 126,050	$ 113,429	$ (12,621)		$ 666,942	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Alloc. From Care Center	AUTO		$ 14,847	$ 2,272	$ 2,276	$ 4		$ 7,325	76
77										77
78										78
79										79
80	TOTALS			$ 14,847	$ 2,272	$ 2,276	$ 4		$ 7,325	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,995,917	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 226,549	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 304,580	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 78,031	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,832,559	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number FAIRFAX NURSING HOME # 0038752 Report Period Beginning: 01/01/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions Parking Lot Rental				1,400			4
5	Pinnacle Care allocation				2,156			5
6	Care Center Allocation				3,386			6
7	TOTAL				$ 6,942 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 8,237 Description: (See Attached)
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number FAIRFAX NURSING HOME # 0038752 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number FAIRFAX NURSING HOME # 0038752 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 69,009	$		$ 69,009	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			9,382			9,382	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			79,352			79,352	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				93,729		93,729	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):			195,191			242,147		437,338	13
14	TOTAL			$ 195,191		$ 157,743	$ 335,876		$ 688,810	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number FAIRFAX NURSING HOME # 0038752 Report Period Beginning: 01/01/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 600	$ 22,335	1
2	Cash-Patient Deposits	56,622	56,622	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,036,924	1,036,924	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	63,637	63,637	6
7	Other Prepaid Expenses	9,338	9,338	7
8	Accounts Receivable (owners or related parties)	42,800	4,691,894	8
9	Other(specify): See supplemental schedule	(88,131)	13,556	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,121,790	$ 5,894,306	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		575,177	13
14	Buildings, at Historical Cost		2,906,534	14
15	Leasehold Improvements, at Historical Cost	794,750	794,750	15
16	Equipment, at Historical Cost	382,994	1,147,884	16
17	Accumulated Depreciation (book methods)	(389,830)	(1,716,778)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule		67,457	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 787,914	$ 3,775,024	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,909,704	$ 9,669,330	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 403,673	$ 403,674	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	56,292	56,292	28
29	Short-Term Notes Payable	826,940	826,940	29
30	Accrued Salaries Payable	238,665	238,665	30
31	Accrued Taxes Payable (excluding real estate taxes)	37,280	37,280	31
32	Accrued Real Estate Taxes(Sch.IX-B)	226,020	226,020	32
33	Accrued Interest Payable	56,651	89,477	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See supplemental schedule	2,019,267	2,019,267	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,864,788	$ 3,897,615	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,653,974	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 6,653,974	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,864,788	$ 10,551,589	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,955,084)	$ (882,259)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,909,704	$ 9,669,330	48

*(See instructions.)

Facility Name & ID Number FAIRFAX NURSING HOME # 0038752 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,114,009)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,114,009)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(841,075)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (841,075)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,955,084)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number FAIRFAX NURSING HOME # 0038752 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,898,876	1
2	Discounts and Allowances for all Levels	(969,028)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,929,848	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	785,878	6
7	Oxygen	47,039	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 832,917	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	21	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	110,467	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	17,408	19
20	Radiology and X-Ray	3,000	20
21	Other Medical Services	1,046,388	21
22	Laundry	1,001	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,178,285	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,419	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,419	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	279	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 279	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,944,748	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	987,850	31
32	Health Care	2,451,264	32
33	General Administration	1,314,324	33
	B. Capital Expense		
34	Ownership	1,255,975	34
	C. Ancillary Expense		
35	Special Cost Centers	688,810	35
36	Provider Participation Fee	87,600	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,785,823	40
41	**Income before Income Taxes (line 30 minus line 40)****	(841,075)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (841,075)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? not complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number FAIRFAX NURSING HOME # 0038752 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	751	844	$ 26,289	$ 31.15	1
2	Assistant Director of Nursing	2,016	2,192	61,393	28.01	2
3	Registered Nurses	23,318	26,165	537,568	20.55	3
4	Licensed Practical Nurses	23,922	25,954	482,173	18.58	4
5	Nurse Aides & Orderlies	82,470	94,014	877,361	9.33	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	10,024	10,985	195,191	17.77	7
8	Rehab/Therapy Aides	5,060	5,813	82,464	14.19	8
9	Activity Director	1,848	2,083	28,505	13.68	9
10	Activity Assistants	10,424	11,094	83,924	7.56	10
11	Social Service Workers	4,888	5,545	62,322	11.24	11
12	Dietician					12
13	Food Service Supervisor	1,851	2,091	38,888	18.60	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,313	19,426	158,567	8.16	15
16	Dishwashers					16
17	Maintenance Workers	5,014	5,449	70,394	12.92	17
18	Housekeepers	18,427	20,235	159,717	7.89	18
19	Laundry	9,627	10,902	93,595	8.59	19
20	Administrator	1,040	1,040	30,426	29.26	20
21	Assistant Administrator	704	720	20,916	29.05	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,536	9,501	137,228	14.44	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,858	2,244	29,428	13.11	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	230,091	256,297	$ 3,176,349 *	$ 12.39	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 12,555	01-03	35
36	Medical Director	Monthly	22,425	09-03	36
37	Medical Records Consultant	Fee Basis	1,313	10-03	37
38	Nurse Consultant	Monthly	2,708	10-03	38
39	Pharmacist Consultant	Monthly	3,340	10-03	39
40	Physical Therapy Consultant	198	9,878	10a-03	40
41	Occupational Therapy Consultant	146	7,265	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	48	2,304	11-03	44
45	Social Service Consultant	37	2,073	12-03	45
46	Other(specify)				46
47					47
48	CCI Salaries-(See Attached)		55,765		48
49	TOTAL (lines 35 - 48)	429	$ 119,626		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number FAIRFAX NURSING HOME # 0038752 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Andrew Steiner-08/01/01-12/31/01	Administrator	0.00%	$ 25,355
Kristen Hogan-07/01/01-07/31/01	Administrator	0.00%	5,071
Kristen Hogan-01/01/01-06/30/01	Asst Admin	0.00%	20,916
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 51,342

B. Administrative - Other

Description	Amount
Chris Wayer	$ 3,175
CCI Administrative Payroll	28,301
TOTAL (agree to Schedule V, line 17, col. 3)	$ 31,476
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg & Rothblatt	Accounting	$ 19,045
Crowe Chizek	Accounting	502
Winston & Strawn	Legal	46,898
Meyer Magence	Legal	394
Personnel Planners	Unemployment Consultant	4,374
Maxxsourse	Computer	1,820
Alpha Data	Computer	4,949
Wilk & Waller	Collection	1,302
Amershield	Collection	2,485
American Express Tax Service	Tax Service	1,189
Pinnacle Care Health Services	Home Office Expense	18,848
Care Center, Inc.	Various (See Attached)	125,800
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 227,605

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 68,551
Unemployment Compensation Insurance	25,809
FICA Taxes	242,991
Employee Health Insurance	104,725
Employee Meals	24,090
Illinois Municipal Retirement Fund (IMRF)*	
Pension	23,034
Employee Physicals	1,510
Holiday Expense	4,086
Misc Employee Welfare	5,272
Pinnacle Allocation	1,117
TOTAL (agree to Schedule V, line 22, col.8)	$ 501,184

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	16,646
Health Care Worker Background Check	
(Indicate # of checks performed 109)	1,312
Dues & Subscriptions	3,975
Advertising & Promotion	18,415
Yellow Page Advertising	600
Licenses & Fees	8,849
Care Center Allocation	1,259
Less: Public Relations Expense	
Non-allowable advertising	(18,415)
Yellow page advertising	(600)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 32,041

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,951
Educational Materials	361
Care Center Allocation	901
Entertainment Expense	
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,213

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number FAIRFAX NURSING HOME # 0038752 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number FAIRFAX NURSING HOME # 0038752 Report Period Beginning: 01/01/01 Ending: 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL Council on LTC - $3,830.40**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,651** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? **X** YES _____ NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **87,600**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **24,090** Has any meal income been offset against related costs? **YES** Indicate the amount. $ **21**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? _____ If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **NONE**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **Frost, Ruttenberg & Rothblatt** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **NO** If no, please explain. **Not complete as of 03-31-02**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees